Commentary on: "Spinal Myeloid Sarcoma 'Chloroma' Presenting as Cervical Radiculopathy: Case Report"

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The authors report on their unique experience with a patient harboring a cervical spinal myeloid sarcoma presenting with cervical radiculopathy and neck pain. The authors succinctly present a rare clinical presentation of cervical radiculopathy and neck pain in an otherwise healthy 43-year-old man. Their diagnostic workup revealed a posterior extradural extramedullary epidural and soft tissue cervical mass spanning the cervicothoracic junction. Multidisciplinary treatment was followed with surgical debulking and biopsy, followed by diagnosis of the primary myeloproliferative neoplasm by bone biopsy. The patient received adjuvant chemoradiation. Follow-up visual analog scale scores were all improved, and his preoperative symptoms resolved. In addition, he showed local control of the soft tissue and epidural cervical disease on follow-up imaging.

In the operative intervention, the authors chose a midline approach with laminectomy and decompression of the epidural tumor without posterior stabilization. Their follow-up imaging showed no evidence of destabilization or kyphosis. This approach is reasonable and appropriate for posterior midline epidural disease. Care must be taken, as is known, to minimize the soft tissue dissection and facet violation during laminectomy to prevent deformity. An argument may be made to perform an instrumented arthrodesis given the fact that the lesion and laminectomy spanned the cervicothoracic junction and that there was no known primary at the time, making it difficult to prognosticate the overall expected length of survival, which others have shown can influence the aggressiveness of surgical management.[1]

Though this is not an unreported presentation, it is a rare pathology[2,3]; the previously published literature does support the same treatment paradigm that was undertaken for this patient. Surgical decompression with adjuvant chemoradiation has been the standard used by other practitioners.[3,4]

In summary, the authors effectively share their case report of cervical spinal myeloid sarcoma presenting with radiculopathy. The case outlines their treatment and highlights the insidious course this pathology took in a patient who otherwise appeared healthy. Tumors of any variety should always be kept in the differential diagnosis when evaluating patients with neurologic symptoms.

References

1 Choi D, Crockard A, Bunger C, et al; Global Spine Tumor Study Group. Review of metastatic spine tumour classification and indications for surgery: the consensus statement of the Global Spine Tumour Study Group. Eur Spine J 2010;19(2):215–222
2 Kurian CJ, Madhavan I, Krishnankutty PK, Andrews MA. Compressive myelopathy caused by isolated epidural myeloid sarcoma with systemic mastocytosis. Rare presentation of a hematological malignancy. Neurosciences (Riyadh) 2014;19(3):238–239
3 Isshiki Y, Ohwada C, Togasaki E, et al. Acute myeloid leukemia concurrent with spinal epidural extramedullary myeloid sarcoma accompanied by a high CD25 expression and the FLT3-ITD mutation. Intern Med 2014;53(11):1159–1164
4 Xu J, Zhao H, Jiang T, et al. Granulocytic sarcoma, an undiagnosed leukemia, initially manifested as paralysis. Neuroendocrinol Lett 2011;32(3):234–237

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